

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11919 CERTIFICATE OF DEATH

11916

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poocomoke City		c. LENGTH OF STAY IN 1b 8 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 812 Second Street		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 42 Poocomoke City	
3. NAME OF DECEASED (Type or print) Lidia		First O.	Middle Bunting
4. DATE OF DEATH October	Month 1	Day Year 1, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 26, 1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (State or foreign country) Virginia
13. FATHER'S NAME Smith Onley		14. MOTHER'S MAIDEN NAME Elizabeth Stant	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs Dorsey Wessells, Poocomoke City, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  Cerebral Hemorrhage Arteriosclerosis, generalized INTERVAL BETWEEN ONSET AND DEATH 1 week years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) M.D.	(County)	(State)	
21. I certify that I attended the deceased from <u>Sept 30</u> , 1958, to <u>Oct 1</u> , 1958, that I last saw the deceased alive on <u>Sept 30</u> , 1958, and that death occurred at <u>3309</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Charles W. Trader 302 Market St., Poocomoke City, Md. 10-1-58 DATE SIGNED 10-1-58			
ACTUAL SIGNATURE			
PHYSICIAN'S NAME (Type) Charles W. Trader			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-3-58	22c. NAME OF CEMETERY Bethany Methodist	22d. LOCATION (City, town, or county) Pocomoke City, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE Henry J. Watson	ADDRESS Poocomoke, Md.	24a. REC'D BY REGISTRAR DATE OCT 6 '58	24b. REGISTRAR'S SIGNATURE Charles E. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained in a hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

11917

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		11921 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Girdletree</i>		c. LENGTH OF STAY IN 1b 1		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Girdletree, Maryland</i>		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Home</i>				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Peter</i>	Middle <i>J.</i>	Last <i>Conner</i>	4. DATE OF DEATH Month <i>10</i>	Day <i>7</i>	Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-4-87</i>	9. AGE (In years last birthday) <i>71</i> yrs.	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Farm Work</i>	11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>Kallup Carter</i>	14. MOTHER'S MAIDEN NAME <i>Annie Tull</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Bessie Conner</i>	Address <i>Girdletree, Md.</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>uremia</i> 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>arteriosclerotic cardio-renal</i> DUE TO (c) <i>disease</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 wk</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m. 19	Month 19	Day	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>Sept 1, 1958</i> to <i>Oct 7, 1958</i> that I last saw the deceased alive on <i>Oct 7, 1958</i> , and that death occurred at <i>10:15 PM</i> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>Girdletree, Md.</i>	
ACTUAL SIGNATURE <i>Paul Cohen</i>	M.D.					DATE SIGNED <i>10-9-58</i>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10-11-58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Cool Spring</i>	22d. LOCATION (City, town, or county) <i>Girdletree, Md.</i>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elgar Wharton - Newchurch, Lt.</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE <i>OCT 14 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Turner</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11918

## 11922 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Worcester</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Berlin</b> RFD		c. LENGTH OF STAY IN 1b <b>10yrd</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>XXXX</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Berlin</b> RFD	
3. NAME OF DECEASED (Type or print) <b>Edward</b>		Middle <b>T.</b>	4. DATE OF DEATH Oct. 7 Month Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 1 1884</b>
9. AGE (In years at time of death <b>74</b> ) yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Auto Mechanic</b>	11. BIRTHPLACE (State or foreign country) <b>London England</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Unknown</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>XXX</b>		17. INFORMANT <b>Margaret Jennings Berlin, Md. RFD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2-3 days</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO		Hypertensive Cardio-vascular disease ? years.	
(c) DUE TO		Atherosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct. 3</b> , 1958, to <b>Oct. 7</b> , 1958, that I last saw the deceased alive on <b>Oct. 7</b> , 1958, and that death occurred at <b>3:00 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert A. Grubb, M.D.</b>		ADDRESS (Street, city or town, state) <b>BERLIN, MD.</b>	
PHYSICIAN'S NAME (Type) <b>ROBERT A. GRUBB, M.D.</b>		DATE SIGNED <b>10/8/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/10/58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>IOOF</b>
22d. LOCATION (City, town, or county) <b>Bishopville, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Peter Whaley, Selbyville Del.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 10 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knott</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11919

11923

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>		b. COUNTY <i>Wicomico</i>						
c. LENGTH OF STAY IN 1b <i>40 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>310 Park Row</i>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)	First <i>Carrie</i>	Middle <i>B.</i>	Last <i>Johnson</i>					
4. DATE OF DEATH	Month <i>Oct.</i>	Day <i>2</i>	Year <i>1958</i>					
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 18-1873</i>					
9. AGE (In years last birthday) <i>80 yrs/14</i>	10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	Months <i>0</i>	Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		10c. BIRTHPLACE (State or foreign country) <i>Gaithersburg, Ga.</i>				
11. CITIZEN OF WHAT COUNTRY?								
13. FATHER'S NAME <i>Robert Hunter</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Hildebrand</i>		Address <i>Mr. George B. Johnson, Snow Hill, MD</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT				
(Yes, no, or name and if yes, give war or dates of service)								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ACUTE PULMONARY EDEMA</i>		12 HRS						
443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.								
(b) <i>ACUTE CARDIAC DILATATION</i>		1-0 ASY						
DUE TO (c) <i>HYPERTENSIVE CARDIO VASCULAR DISEASE</i>		10 yrs						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Snow Hill</i>	(County) <i>Wicomico</i>	(State) <i>MD</i>
p. m.								
21. I certify that I attended the deceased from <i>1950</i> , to <i>1958</i> , that I last saw the deceased alive on <i>10/2/58</i> , and that death occurred at <i>418/2/58</i> M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>Snow Hill, MD</i>	DATE SIGNED <i>10-3-58</i>	
ACTUAL SIGNATURE <i>Robert C. La Mar</i>								
PHYSICIAN'S NAME (Type) <i>Robert C. La Mar, M.D.</i>						Bay St., Snow Hill, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Oct. 4/58</i>		22b. DATE THEREOF <i>Oct. 4/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Bethel Methodist</i>		22d. LOCATION (City, town, or county) <i>Snow Hill</i>		
						(State) <i>MD</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clay E. Dennis</i>		ADDRESS <i>Snow Hill, MD</i>		24a. REC'D BY REGISTRAR <i>DET 6 '58</i>		24b. REGISTRAR'S SIGNATURE <i>C. Thru S. Kraus</i>		

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OF SPONTANEOUS-FLAMES IN THE TRANSPORTATION INDUSTRY

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11924

## CERTIFICATE OF DEATH

11920

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>		c. LENGTH OF STAY IN 1b <b>92 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <b>R. F. D. #2</b>	
3. NAME OF DECEASED (Type or print) <b>ANNIE JULIA JONES</b>		First	Middle
4. DATE OF DEATH <b>OCT. 12 1958</b>	Month	Day	Year
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 14, 1866</b>
9. AGE (In years last birthday) <b>92 yrs.</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BERLIN MD</b>	
11. BIRTHPLACE (State or foreign country) <b>BERLIN MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>CHARLES RICHARDSON</b>		14. MOTHER'S MAIDEN NAME <b>NELLIE KELLEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Mr. THOMAS Jones BERLIN MD</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		<b>Cerebral vascular accident</b>	
		<b>Severe arteriosclerosis</b>	
		<b>Senility</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 1958</b> to <b>Oct. 12, 1958</b> , that I last saw the deceased alive on <b>Oct. 12, 1958</b> , and that death occurred at <b>3:07 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert A. Grubb</b>		ADDRESS (Street, city or town, state) <b>BERLIN, MD.</b>	
PHYSICIAN'S NAME (Type) <b>ROBERT A. GRUBB, M.D.</b>		DATE SIGNED <b>10/13/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10/14/58</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>TAYLORVILLE</b>		22d. LOCATION (City, town, or county) <b>BERLIN</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna A. Burbage Berlin Md</b>		ADDRESS	
		24a. REC'D BY REGISTRAR <b>OCT 16 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



11921

Reg. Dist. No.

**11925 CERTIFICATE OF DEATH**

**O HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**O FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b>			MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MD</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X BERLIN</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS <b>R.F.D #2</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First <b>BETTY</b>	Middle <b>ANNE</b>	Last <b>JOSEPH</b>	4. DATE OF DEATH <b>OCT. 22 1958</b>	Month <b>OCT.</b>	Day <b>22</b>	Year <b>1958</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 9, 1890</b>		9. AGE (In years last birthday) <b>68 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>		11. IF UNDER 24 HRS. Days <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BERLIN MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>ANDREW RICHARDSON</b>			14. MOTHER'S MAIDEN NAME <b>ELEANOR POWELL</b>			Address <b>BERLIN MD</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <b>No</b> 17. INFORMANT <b>MR. WALTER JOSEPH</b>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>General Apoplexy sec</b> DUE TO <b>442x</b> INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Generalized atresia cerebral</b> DUE TO <b>3-4 yrs</b> (c) <b>Hypertension and Cardi-Vascular Disease</b> DUE TO <b>6-7 yrs</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic Bronchitis &amp; Bronchectasis - 8-4 yrs</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <b>20c. TIME OF INJURY Month. Day. Year Hour a. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>		
21. I certify that I attended the deceased from <b>Jan 1, 1957</b> to <b>Oct 22, 1958</b> that I last saw the deceased alive on <b>Oct 22, 1958</b> , and that death occurred at <b>6 A.M.</b> from the causes and on the date stated above.									ADDRESS (Street, city or town, state) <b>Berlin, Md.</b>		DATE SIGNED <b>10/23/58</b>
ACTUAL SIGNATURE <b>Herman A. Raborn</b>		M.D.									
PHYSICIAN'S NAME (Type)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10/25/58</b>		22c. NAME OF CEMETERY OR CEMETORY <b>EVERGREEN</b>		22d. LOCATION (City, town, or county) <b>BERLIN</b> (State) <b>MD</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna A. Burbage Berlin Md</b>			ADDRESS		24a. REC'D BY REGISTRAR <b>OCT 27 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Caroline S. Kline</b>				

## CERTIFICATE OF DEATH

1976

MURKIN

JOHN J. MURKIN  
MURKIN

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11922

## 11926 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishopsville		c. LENGTH OF STAY IN lb 52 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION XXX		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishopsville	
3. NAME OF DECEASED (Type or print) ANNIE		First NEAL	Middle LAW
4. DATE OF DEATH Oct. 23		Month 1958	Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23, 1864
9. AGE (In years lost birthday) 93		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Delaware
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Neal		14. MOTHER'S MAIDEN NAME Hester Dodd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Hester Dunn
		Address Bishopsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.2 DUE TO Metastatic carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any. (b) DUE TO site of primary lesion not definitive (c) Senility			
INTERVAL BETWEEN ONSET AND DEATH 10 mo			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 39
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE V. A. Hudson, M.D.			
PHYSICIAN'S NAME (Type) V. A. Hudson, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/25/58	22c. NAME OF CEMETERY OR CREMATORIUM 100 F
22d. LOCATION (City, town, or county) Bishopsville, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley, Silver Spring, Md.		24a. REC'D BY REGISTRAR OCT 27 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of the death.

## CERTIFICATE OF DEATH

11/1/19

Date of Birth

Age

Sex

Race

Cause of Death: *Obstruction of the larynx by a foreign body*Time of Death: *10:00 AM*Place of Death: *Emergency Room*Name of Hospital: *Johns Hopkins Hospital*Name of Physician: *Dr. John H. Johnson*Name of Coroner: *John H. Johnson*Name of Pathologist: *John H. Johnson*Name of Hospital: *Johns Hopkins Hospital*Name of Physician: *John H. Johnson*Name of Coroner: *John H. Johnson*Name of Pathologist: *John H. Johnson*Name of Hospital: *Johns Hopkins Hospital*Name of Physician: *John H. Johnson*Name of Coroner: *John H. Johnson*Name of Pathologist: *John H. Johnson*Name of Hospital: *Johns Hopkins Hospital*Name of Physician: *John H. Johnson*Name of Coroner: *John H. Johnson*Name of Pathologist: *John H. Johnson*Name of Hospital: *Johns Hopkins Hospital*Name of Physician: *John H. Johnson*Name of Coroner: *John H. Johnson*Name of Pathologist: *John H. Johnson*Name of Hospital: *Johns Hopkins Hospital*Name of Physician: *John H. Johnson*Name of Coroner: *John H. Johnson*Name of Pathologist: *John H. Johnson*Name of Hospital: *Johns Hopkins Hospital*Name of Physician: *John H. Johnson*Name of Coroner: *John H. Johnson*Name of Pathologist: *John H. Johnson*Name of Hospital: *Johns Hopkins Hospital*Name of Physician: *John H. Johnson*Name of Coroner: *John H. Johnson*Name of Pathologist: *John H. Johnson*

G.M.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11927 CERTIFICATE OF DEATH

Reg. Dist. No.

11923

1. PLACE OF DEATH o. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop		b. COUNTY Worcester	
c. LENGTH OF STAY IN lb 40 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION XXX		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First VERNON	Middle M.	4. DATE OF DEATH Oct. 4 Month Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 21, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	9. AGE (In years last birthday) 69 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
13. FATHER'S NAME Mack Long		11. BIRTHPLACE (State or foreign country) Delaware	12. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 220-34-7626	17. INFORMANT Margaret Long
		Address Bishop, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>451x</i> <i>ruptured abdominal aortic aneurysm</i> minutes DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>abdominal aortic aneurysm</i> 1 year DUE TO (c) <i>atherosclerosis severe</i> years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertension</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>October</i> , 1958, to <i>October 4</i> , 1958, that I last saw the deceased alive on <i>October 4</i> , 1958, and that death occurred at <i>1:17 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert A. Grubb, M.D.</i>		ADDRESS (Street, city or town, state) <i>Berlin, Md.</i> DATE SIGNED <i>10/6/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/7/58	22c. NAME OF CEMETERY OR CREMATORIAL Red Men
22d. LOCATION (City, town, or county) <i>Selbyville, Del.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Peter Whaley Selbyville, Del.</i>		24a. REC'D BY REGISTRAR OCT 8 '58	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

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## CERTIFICATE OF DEATH

Date of Birth

Name of  
DeceasedDate of  
Death Deceased  Deceased  Deceased  Deceased Deceased  Deceased  Deceased  Deceased

Date of Birth (approximate) 1880-01-01-1882

Date of Death (approximate) 1940

Cause of Death

Obituary

Death Certificate

Death Record

Signature

Signature

Signature

Signature

Signature

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11924

11928

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>		b. COUNTY <i>Worcester</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Guldtree</i>		c. LENGTH OF STAY IN lb <i>63 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Guldtree</i>		d. STREET ADDRESS <i>X Guldtree</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <i>Willett</i>	Middle <i>Mae</i>	Lost <i>Robinson</i>	4. DATE OF DEATH Month <i>Oct.</i>	Day <i>26</i>	Year <i>1958</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 30-1905</i>		9. AGE (In years last birthday) <i>63 yrs</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		11. BIRTHPLACE (State or foreign country) <i>Guldtree, MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Henry C. Riley</i>		14. MOTHER'S MAIDEN NAME <i>Mary E. Lewis</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>Open</i>		17. INFORMANT <i>Mr. Arthur J. Robinson, Guldtree, MD</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i>		DUE TO  (b) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Cerebral Accident		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>		
		DUE TO  (c) Hyper tension Arteriosclerosis disease				14 Year		
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Guldtree</i>		20f. (City or town) <i>Guldtree</i>	(County) <i>Worcester</i>	(State) <i>MD</i>
21. I certify that I attended the deceased from <i>Oct 26</i> , 19 <i>57</i> , to <i>Oct 26</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Oct 26</i> , 19 <i>58</i> , and that death occurred at <i>11:55 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Paul Cohen</i>		ADDRESS (Street, city or town, state) <i>Guldtree, MD</i>						DATE SIGNED <i>10/27/58</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Oct 29/58</i>		22b. DATE THEREOF <i>Oct 29/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Baptist Cemetery</i>		22d. LOCATION (City, town, or county) <i>Guldtree</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>George Dennis</i>		ADDRESS <i>Snow Hill, MD</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 28 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>		

СТАНОВЛЕНИЕ НАШЕГО ПОЛИТИЧЕСКОГО СТАТУСА  
СТАНОВЛЕНИЕ НАШЕГО СТАТУСА

1917 г.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11929

### CERTIFICATE OF DEATH

Reg. Dist. No.

11925

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>		c. LENGTH OF STAY IN 1b <i>40 yrs</i>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Hazel M. Rounds</i>		4. DATE OF DEATH Month <i>Oct.</i>	Year <i>23 1958</i>
5. SEX <i>Female</i>		6. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <i>Nov. 16-1917</i>	
10a. USUAL/OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
11. BIRTHPLACE (State or foreign country) <i>Snow Hill, MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>Snow Hill, MD</i>	
13. FATHER'S NAME <i>Joseph Ayres</i>		14. MOTHER'S MAIDEN NAME <i>Georgia Price</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-14-3545</i>	
17. INFORMANT <i>Mr. James D. Rounds</i>		Address <i>Snow Hill, MD</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i>		DUE TO <i>Acute Pulmonary Edema</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hyper tension</i>		DUE TO <i>Cardiovascular disease</i>	
(c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 mo.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <i>104 Bay St., Snow Hill, Md.</i>	
21. I certify that I attended the deceased from <i>1950</i> , to <i>1958</i> , that I last saw the deceased alive on <i>10/22/58</i> , and that death occurred at <i>104 Bay St., Snow Hill, Md.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert C. LaMar</i>		ADDRESS (Street, city or town, state) <i>104 Bay St., Snow Hill, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Robert C. LaMar, M.D.</i>		DATE SIGNED <i>10-24-58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Oct 27 '58</i>		22b. DATE THEREOF <i>Oct 27 '58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Worley Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Snow Hill, MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clay B. Dennis</i>		24a. REC'D BY REGISTRAR ADDRESS <i>Snow Hill, MD</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
		DATE OCT 27 '58	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled in with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG235 10-28-58 et

11920

## CERTIFICATE OF DEATH

Reg. Dist. No.

11926

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WORCESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke</b>		c. LENGTH OF STAY IN 1b <b>7 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		42. POOCOMOKE 11409 MARKET ST	
3. NAME OF DECEASED (Type or print) <b>CARRIE</b>		First <b>WESSELLS</b>	Middle <b>STERLING</b>
4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>19</b> Year <b>1958</b>		5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 11/20/1889	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <b>68</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM J. WESSELLS</b>		14. MOTHER'S MAIDEN NAME <b>SADIE TRADER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>111-11-1111</b>	
17. INFORMANT <b>MRS. PURNELL HOSIER</b>		18. ADDRESS <b>NEWCHURCH, VA</b>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Generalized Arteriosclerosis</b>		DUE TO <b>and Hypertension.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Adenocarcinoma, uterus</b>		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Apr. 17, 1958</b> to <b>Oct. 19, 1958</b> , that I last saw the deceased alive on <b>Oct. 19, 1958</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Charles W. Trader, M.D.</b>	
ACTUAL SIGNATURE <b>Charles W. Trader, M.D.</b>		DATE SIGNED <b>Oct. 20, 1958</b>	
PHYSICIAN'S NAME (Type) <b>Charles W. Trader, M.D.</b>		302 Market St., Pocomoke City, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL 10/22/58</b>		22b. DATE THEREOF <b>10/22/58</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>GROTONS</b>		22d. LOCATION (City, town, or county) <b>HALLWOOD</b> (State) <b>VA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry M. Johnson Parkaley, Jr.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 24 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Haas</b>	

DEPARTMENT OF STATE  
CELEBRATE 9/11

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11927

11930

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>		c. LENGTH OF STAY IN 1b <b>15 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>	
3. NAME OF DECEASED (Type or print) <b>Lydia May Willing</b>		d. STREET ADDRESS <b>R.F.D. #2</b>	
4. DATE OF DEATH <b>OCTOBER 18 1958</b>	Month Year	Day	Year
5. SEX <b>F</b>	6. COLOR OR RACE <b>WV</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 21, 1905</b>
9. AGE (In years last birthday) <b>53 yrs.</b>	10. IF UNDER 1 YEAR Months <b>5</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>Pocomoke City, MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES G. BEAUCHAMA</b>		14. MOTHER'S MAIDEN NAME <b>ANNA BELLE COLLINS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Mr. WALTER Willing, BERLIN MD</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>581.0</b> DUE TO Cirrhosis of Liver	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 16 1958</b> to <b>Oct 18 1958</b> , that I last saw the deceased alive on <b>Oct 17 1958</b> , and that death occurred at <b>4A M</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Ocean City, MD</b>	
ACTUAL SIGNATURE <b>F. J. Townsend Jr.</b>		DATE SIGNED <b>Oct 18, 1958</b>	
PHYSICIAN'S NAME (Type) <b>F. J. Townsend Jr.</b>		22d. LOCATION (City, town, or county) (State) <b>SALISBURY MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10/20/58</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>WICOMICO MEMORIAL</b>		22d. LOCATION (City, town, or county) (State) <b>MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna D. Burbage Berlin MD.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 21 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

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